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General Scheme of Access to Abortion Bill 2015

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GENERAL SCHEME OF ACCESS TO ABORTION BILL 2015*

An Act to respect human life during pregnancy by affirming pregnant women's constitutional rights; recognising that sustaining embryonic and foetal life in pregnancy is an important social role, which should be voluntary and consensual, and enabling access to abortion, and in respect of related matters.

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Part 1 – Preliminary and General

Head 1: Short Title and Commencement

- (1) This Act may be cited as the Access to Abortion Act 2015.
- (2) This Act shall come into operation on such day or days as the Minister for Justice and Equality may, following consultation with the Minister for Health, appoint by order or orders either generally or with reference to any particular purpose or provision and different days may be so appointed for different purposes or different provisions.

Head 2: Interpretation

“*abortion*” means intentionally causing the miscarriage of a pregnancy (or, in the case of a woman carrying more than one foetus, the miscarriage of any foetus) by using an instrument or using a drug or a combination of drugs, or any other means.

“*authorised location*” refers to the schedule of “appropriate institutions” identified under the Schedule to the Protection of Life During Pregnancy Act 2013, General Practitioner offices, and places approved by the Department of Health under this Act.

“*health*” means a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

“pregnant woman” includes pregnant minors, and pregnant intersex and transgender persons.

Explanatory note

It is very rare for national laws to define abortion. Where a definition is included, it is typically a definition of a criminal offence (in those jurisdictions which still criminalise abortion) and not of a group of medical procedures. However, we include this definition here to take account of the prevailing Irish context. It is important to distinguish abortion as provided for under these Heads from other procedures falling under the broader category of ‘termination of pregnancy’ as provided for under the Implementation Guidelines to the Protection of Life During Pregnancy Act 2013 (PLDPA).¹ In other jurisdictions, it is accepted that the phrase ‘termination of pregnancy’ is synonymous with abortion. In Ireland under the PLDPA, however, the same phrase appears to have come to include early delivery by induction or Caesarean section.² Therefore, we use the word ‘miscarriage’ in the definition of abortion to ensure that, where a pregnant woman is entitled to an abortion, that there is a statutory obligation to provide her with such a procedure. In no circumstances would it be appropriate to substitute medical procedures designed to prolong pregnancy or result in a live birth for abortion as provided for in this Act. In addition, the fact that a pregnant person has requested, and been refused access to an abortion, should have no bearing on subsequent care, including the types of treatment offered to her. These points should be clarified in the Code of Practice under Head 16.

The use of the word ‘miscarriage’ also affirms that the Act has no application to the embryo prior to implantation.

As to ‘authorised location’ we note that it will not be necessary for all abortions performed under the Act to be restricted to hospitals. The Act should leave scope for the future licensing of additional locations in accordance with best medical practice; for instance, specialised public or private clinics, GPs’ clinics (or individuals’ own homes in the case of early medical abortion).

The definition of ‘health’ here is that adopted by the World Health Organisation.³ The adoption of this definition of health is important in signaling the Act’s new focus on the dignity and welfare of the pregnant woman in the wake of the repeal of the 8th

¹ Department of Health, *Implementation of the Protection of Life During Pregnancy Act 2013: Guidance Document for Health Professionals* (2014).

² *Ibid.*

³ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946. The International Covenant on Economic, Social and Cultural Rights recognises in Article 12, “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” while article 12(2) enumerates, by way of illustration, a number of “steps to be taken by the States parties ... to achieve the full realization of this right”. Additionally, the right to health is recognised in Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965 and in Articles 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979. See further Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C12/2000/4 (2000).

Amendment. It necessarily includes a state of physical, psychological and socio-cultural wellbeing in aspects related to sexuality and reproduction. This implies a safe sex life and the right to make decisions around pregnancy free from coercion, discrimination or violence. The definition, consistent with the Guiding Principles in Head 3, assumes the right to freedom from non-consensual medical treatment, and the right of effective access to healthcare. It also removes the unnecessary distinction between physical and mental illness found in the PLDPA.

Head 3: Guiding Principles

Provide that:

1. Access to abortion is guaranteed in accordance with the provisions of this Act.
2. In making any decision under the Act, or in providing medical care and services under this Act, the Heads shall be interpreted in the manner most favourable to achieving positive health outcomes for the pregnant woman, and to the protection of her rights, including the rights to:
 - a. life;
 - b. freedom from torture, cruel, inhuman and degrading treatment;⁴
 - c. bodily integrity and autonomy;⁵
 - d. self-determination, including the right to informed decision-making in relation to medical treatment;⁶
 - e. private and family life,⁷ including the right to privacy.⁸
 - f. health,⁹ including the right of access to appropriate health-care in a safe, prompt and timely fashion,¹⁰ and the right of access to healthcare information.¹¹

⁴ *P. and S. v. Poland*, No. 57375/08 Eur. Ct. H.R. para. 168 (2008); *R.R. v. Poland* [2011] E.C.H.R. 828, para. 161; Human Rights Committee, *Concluding Observations: Ireland*, para. 9, U.N. Doc. CCPR/C/IRL/CO/4 (2014); Human Rights Committee, *Concluding Observations: Ireland*, A/55/40[VOL.I] (SUPP) (2000); *K.L. v. Peru*, Human Rights Committee, Commc'n No. 1153/2003, para. 6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); *L.M.R. v. Argentina*, Human Rights Committee, Commc'n No. 1608/2007, para. 9.2, U.N. Doc. CCPR/C/101/D/1608/2007 (2011).

⁵ *Ryan v. Attorney General* [1965] 1 I.R. 264; *The State (C) v. Frawley* [1976] 1 I.R. 365.

⁶ *R.R. v. Poland* [2011] E.C.H.R. 828, para. 181; Beijing Declaration and the Platform for Action, Fourth World Conference on Women, Beijing, China, Sept. 4-15 1995, para. 96: women have the "right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence".

⁷ *Tysiqc v. Poland* [2007] E.C.H.R. 219, para. 66.

⁸ Article 41.1, Constitution of Ireland; *McGee v Attorney General* [1974] IR 284; *Kennedy v Ireland* [1987] IR 587; *Heaney v Ireland* [1994] 3 IR 593; *Tysiqc v. Poland* [2007] E.C.H.R. 219, paras. 106-107; *R.R. v. Poland* [2011] E.C.H.R. 828, para. 181; *P. and S. v. Poland*, No. 57375/08 Eur. Ct. H.R. para. 96 (2008); *K.L. v. Peru*, Human Rights Committee, Commc'n No. 1153/2003, para. 6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); *L.M.R. v. Argentina*, Human Rights Committee, Commc'n No. 1608/2007, para. 9.3, U.N. Doc. CCPR/C/101/D/1608/2007 (2011); Human Rights Committee, *Concluding Observations: Ireland*, para. 9.

⁹ *L.C. v. Peru*, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

¹⁰ General Comment No. 14 of the CESCR Committee on the right to health under Article 12 ICESCR provides that the right to health extends to "control one's health and body, including sexual and reproductive freedom and the right to be free from interference". The General Comment makes clear

3. Access to abortion services will not be impeded because of race, sex, religion, national, ethnic or social origin, disability, HIV status, marital or family status, immigration status, sexual orientation, age, birth or other social status.¹²
4. Sustaining embryonic and foetal life in pregnancy is an important social role, which should be voluntary and consensual.

Explanatory note

We have suggested these Guiding Principles because we recognise that the repeal of the 8th Amendment entails a significant ‘culture shift’ in the Irish legal approach to abortion and obstetric care. Doctors will be required to assess a pregnant woman’s entitlement to abortion across a wider range of grounds than under the PLDPA. In addition, they will have to make decisions in a new legal environment in which the pregnant woman’s rights are of higher priority than they have been in the past. The explicit inclusion of these principles is designed to ensure that a pregnant woman’s constitutional and other human rights are to the fore at every stage of the decision-making process.

These principles should guide doctors (i) in responding to a pregnant woman’s request for an abortion under Heads 5-9, (ii) in determining the appropriate treatment to offer where a pregnant woman’s request for an abortion has been granted under one of those Heads, and (iii) in the manner of provision of the treatment itself. As such they should inform the drafting of the Code of Practice under Head 16. In order to avoid the unnecessary development of ‘chilling effects’, the Code should provide sufficient clarity on the application of the Guiding Principles to enable medical practitioners to apply them with a reasonable degree of certainty in providing appropriate woman-centred care.

These principles should also guide all decisions of tribunals under Head 14, and inform the associated Code of Practice.

that any and all barriers to women’s right to control of their own health should be removed, including barriers interfering with access to health services, education and information. See *L.C. v. Peru*, CEDAW Committee, Commc’n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

¹¹ *R.R. v. Poland*, No. 27617/04 Eur. Ct. H. R., para. 197 (2011); *Open Door and Dublin Well Woman v. Ireland* [1992] E.C.H.R. 68, para. 72; *Guerra and others v. Italy*, No. 116/1996/735/932 Eur. Ct. H. R., para. 60 (1998); *Roche v. United Kingdom* (2006) 42 E.H.R.R. 30, para. 155; *Codarcea v. Romania*, No. 31675/04, Eur. Ct. H. R., para. 105 (2009).

¹² Article 40.1, Constitution of Ireland; *Stec and Others v. the United Kingdom* [2006] E.C.H.R. 393, para. 51; *L.C. v. Peru*, CEDAW Committee, Commc’n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011). Note in particular, Article 12 of CEDAW which requires that “States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning”.

Part 2: Decriminalisation

Head 4: Decriminalisation

Provide that:

Notwithstanding any other Act or law:

1. A pregnant woman who consents to or assists in the performance of an abortion on herself is not guilty of any offence.
2. A person is not guilty of an offence by reason of having performed an abortion on a pregnant woman in accordance with this Act, or assisting in, or counseling a woman in relation to the performance of an abortion in accordance with this Act
3. A person is not guilty of any offence by reason of having made an appointment or any other arrangement for or on behalf of a pregnant woman with a person who provides abortion services in accordance with this Act.
4. A person is not guilty of any offence by reason of having made an appointment or any other arrangement for or on behalf of a pregnant woman with a person who provides services outside the State for the termination of pregnancies

Explanatory Note

We expect that decriminalisation will be effected by repealing the PLDPA 2013 and Regulation of Information (Services Outside the State for Termination of Pregnancies) Act 1995 in full. Sub-heads 3 and 4 in particular are intended to copper-fasten repeal of the 1995 Act.

The explicit statement of decriminalisation suggested above is a necessary step towards extinguishing any residual chilling effect¹³ arising from the perceived threat of prosecution. The wording is broad enough to cover the activities of doctors, midwives, nurses, pregnancy counsellors and others.

There are several justifications for decriminalisation:¹⁴

- Once the 8th Amendment is repealed, there is no longer any constitutional imperative for criminalisation either of abortion procedures, or of the provision of abortion information.
- Doctors who do not carry out legal abortions appropriately are already subject to regulatory sanctions from within their own professional bodies, as well as to

¹³ *A., B. & C. v. Ireland* (2011) 53 E.H.R.R. 13, para. 254; Doctors for Choice, *Submission to the United Nations Human Rights Committee for Ireland's Review under the International Covenant on Civil and Political Rights*, at 26 (June 12, 2014). Available at http://www.ccprcentre.org/doc/2014/06/INT_CCPR_CSS_IRL_17440_E.pdf (last accessed 29 May 2015).

¹⁴ See further Interim Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/443/58/PDF/N1144358.pdf?OpenElement> (last accessed 29 May 2015).

the law of torts, and the broader law on the regulation of hospitals. Harmful unskilled abortions or coerced abortions – the most likely target of s.22 of the PLDPA 2013 – would be caught by the amendments to the criminal law suggested below.

- Decriminalisation will help to address some of the stigma¹⁵ around abortion care. Stigma generates public health problems by discouraging women from accessing appropriate care before and after abortion.
- Repeal of the Regulation of Information (Services Outside the State for Termination of Pregnancies) Act 1995, in particular, will enable fuller provision of information to pregnant women seeking abortion.¹⁶
- Decriminalisation is required by international human rights law.¹⁷

It will be necessary for the Minister to take measures to positively ensure adequate supply and distribution of the drugs mifepristone and misoprostol. We note that both medicines are on the World Health Organisation Model List of Essential Medicines.¹⁸ It is not necessary to create an additional offence of importing these drugs without proper permission, as the law already governs illegal importation of prescription drugs in general terms. Similarly, the law already governs illegal supply of prescription drugs.¹⁹

Part 3: Access to Abortion Care

A General Note on the Categorisation of Risk

Heads 5-9 set out that women are entitled to access an abortion on grounds of risk to health or life, or on the grounds of a diagnosis of fatal foetal abnormality. It is not possible, consistent with the Guidelines in Head 3, to conceive of doctors as ‘gatekeepers’ to abortion under the Act. The role of the medical practitioner under Heads 5-9 is to provide a diagnosis, which then entitles a woman to access appropriate abortion care. Their role, in other words, is to provide an expert opinion on a case-by-case basis. The appraisal of the individual woman’s condition must be based on current scientific knowledge, and must be compatible with international best practice. Having made the appraisal, the doctor’s role is to recommend appropriate

¹⁵ See Human Rights Watch, *A State of Isolation: Access to Abortion for Women in Ireland* (2010, New York: Human Rights Watch). Available at

www.hrw.org/sites/default/files/reports/ireland0110webwcover.pdf (last accessed 29 May 2015).

¹⁶ See *R.R. v. Poland* [2011] E.C.H.R. 828; *P. and S. v. Poland*, App. No. 57375/08, 30 October 2012 (arguing that access to information is essential to self-determination).

¹⁷ Concluding Observations: Honduras, para. 8, U.N. Doc. CCPR/C/HND/CO/1 (2006); Ireland, U.N. Doc. CCPR/C/IRL/CO/3 (2008); Paraguay, para. 10, U.N. Doc. CCPR/C/PRY/CO/2 (2006); Sri Lanka, para. 12, U.N. Doc. CCPR/CO/79/LKA (2004); CEDAW, Concluding Observations: Chile, para. 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); Ireland, para. 185, U.N. Doc. A/54/38 (1999); Mauritius, para. 30, U.N. Doc. CEDAW/C/MAR/CO/5 (2006); CEDAW Committee, Gen. Recommendation No. 24, para. 110.

¹⁸ Available at http://apps.who.int/iris/bitstream/10665/93142/1/EML_18_eng.pdf?ua=1 (last accessed 29 May 2015).

¹⁹ See generally Medicinal Products (Prescription and Control of Supply) Regulations 2003 to 2011 (prohibits supply by mail order of prescription only medicinal products); Medical Products Regulations 2003; Customs Consolidation Act 1876 and the Irish Medicines Board Act 1995.

care for the pregnant woman. Heads 5-7 also require medical practitioners to take account of the woman's wishes and views, indicating a 'partnership' approach to medical decision-making.

A priority in considering the content of these Heads, following *A, B and C v. Ireland*,²⁰ should be to address the 'chilling effect' of any uncertainty as to what the law permits. On the one hand, it is important that doctors are given sufficient latitude to respond to pregnant women's healthcare needs. On the other, it is crucial that the law is sufficiently certain that the Act's interferences with pregnant women's rights do not become arbitrary or her rights become illusory, as where there is a significant variation in the application of grounds from one doctor to the next.²¹

We do not consider that it is necessary to add qualifying language such as 'real' to references to 'risk' in Heads 5-7. Such qualifying language would be unusual in a European context. In any event it is already implicit in the Heads' reference to 'good faith' that the medical practitioners have weighed the risk of continuing pregnancy and come to the conclusion, in line with prevailing medical and ethical standards, that an abortion is an appropriate means of meeting their pregnant patient's medical needs. In particular, we note that the qualifier 'real and substantial' derived from the *X Case*²² would be inappropriate and potentially confusing in a post-8th Amendment legal landscape.

In respect of Head 6 (risk of severe or disabling damage to health) and Head 7 (risk to life) the potential outcome for the woman may be so severe that a relatively low threshold of proof is appropriate. Rigid qualifying language is inappropriate in this context.

Medical practitioners will require substantive guidance on the application of risk-based tests in practice. It has not been possible in the course of our work to conduct in-depth research into the likely approaches Irish medical practitioners would take to the application of the tests in Heads 5-9 in concrete cases. It is not possible to predict likely patterns of behaviour from experience in other jurisdictions, given Ireland's very different recent experience of restrictive abortion laws. In our 'Key Questions' at the end of this report, we argue that such research is a necessary precursor to the final drafting of any abortion legislation, and accompanying Code of Practice under Head 16, in order to anticipate the location of any potential 'chilling effects'. We have also recommended a bi-annual review of the operation of the Code of Practice to enable the identification of chilling effects as they emerge in the early years of the operation of the Act.

²⁰ (2011) 53 E.H.R.R. 13.

²¹ See e.g. the Canadian case of *R v. Morgentaler* [1988] 1 S.C.R. 30 for an account of associated arguments.

²² [1992] 1 I.R. 1.

Head 5: Risk to Health

Provide that:

1. An abortion may be performed by a registered medical practitioner, or other health care practitioners under their supervision, until the end of the twelfth week of pregnancy if
 - a. Two registered medical practitioners are of the opinion, formed in good faith, that the continuance of the pregnancy would entail a risk to the pregnant woman's health; and
 - b. In forming their opinions, both registered medical practitioners have taken account of the pregnant woman's views on the impact of the continuance of the pregnancy on her health.

Explanatory note

This legislation does not make provision for abortion on request. Thus, it is more restrictive than the law in force in the majority of European jurisdictions, and does not fully recognise that women can make informed, conscious and responsible decisions as to whether to carry a pregnancy to term. The legislation only seeks to ensure that women will not be exposed to unacceptable harms as a result of pregnancy. In that spirit, the presence of this ground:

- Helps ensure that women do not have to continue with a pregnancy in situations where it poses a risk to their health. As such, it brings Irish law closer to the requirements of international human rights law and modern medical ethical standards.
- Helps reduce the need for pregnant women to seek treatment abroad and, accordingly, reduces the human rights costs of the current abortion law's reliance on travel,²³ which a number of treaty bodies have recognised as discriminating against pregnant women²⁴ on the basis of socio-economic position, age, disability and migrant status.²⁵

²³ For the moment, the state can argue under the ECHR that the 'right to travel' and avail of abortion care abroad adequately safeguards women's rights. However, no woman who found it impossible to travel abroad e.g. for reasons of poverty or immigration status has appeared before the European Court of Human Rights. It may be that the Court could find a violation of the Convention in those circumstances.

²⁴ See CEDAW Committee, Concluding Observations: Ireland, para. 185, U.N. Doc. CEDAW/C/SR.440 and 441 (1999). 101; Committee Against Torture, Concluding Observations: Ireland, para. 26, U.N. Doc. CAT/C/IRL/CO/1 (2011); Concluding Observations of the Human Rights Committee, (UNHRC), 111th session, 23 July 2014, U.N. Doc. CCPR/C/IRL/CO/4, at para. 9

²⁵ See Human Rights Watch, *A State of Isolation: Access to Abortion for Women in Ireland* (2010, New York: Human Rights Watch) at pp. 22 and 33-34. Available at www.hrw.org/sites/default/files/reports/ireland0110webwcover.pdf (last accessed 29 May 2015). See further Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/23/41 at paras.72-74, noting the particular difficulties which migrant workers experience in accessing abortion. Available at: http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session23/A_HRC_23_41_ENG.pdf (last accessed 29 May 2015); Council of Europe, Parliamentary Assembly Resolution on Access to Safe and Legal Abortion in Europe. Available at

- Brings Irish practice closer to that of other European jurisdictions, while stopping short of the European norm in relation to abortion on request. Almost every European jurisdiction allows abortion *de jure* or *de facto* on request up to 12-14 weeks.²⁶
- Provides an effective statutory pathway for access to early medical abortion. Women in Ireland are already using misoprostol and mifepristone illegally in significant numbers, and will likely continue to do so after repeal of the 8th Amendment. While this is not unsafe in itself (where authentic medications have been sourced from a trustworthy supplier, which is not always the case), women's health is better protected where they have access to appropriate information and advice, medical support and reliable means of procuring necessary medication.
- Allows those whose pregnancy will affect their health to act in early pregnancy rather than waiting for the risk of a more serious condition to manifest itself.

There is no defensible argument that the time period for accessing an abortion under this heading should be any lower than 12 weeks. In particular, it is important to bear in mind that teenagers, or women with irregular menstrual cycles, may not discover that they are pregnant until they have missed two menstrual periods, so that it is not possible to make a decision in the early weeks of pregnancy. It may also be the case that women will delay in seeking treatment in the early years of the Act due to confusion, stigma, or uncertainty as to their legal entitlements. Some may also delay because they are dealing with the after-effects of rape,²⁷ or with some mental health difficulty. A period of 12 weeks, or longer, enables such women to access health-preserving abortion care. In addition, a shorter time period would mean that women are likely to be deprived of access to abortion where they are not able to access a GP who provides abortion care within in a couple of weeks. This difficulty is likely to affect teenagers, or those living in rural areas, and will be heightened if two doctors are required to provide access to treatment. Finally, a shorter time period might cause women to feel pressured to act immediately, when they might prefer to take a week or two to consider their position, to consult with family and friends, and to consider the current and future state of their health.

Risk to Health

The risk to health need not originate with the pregnancy. It can also refer to an independent condition, whether new, pre-existing or recurring, or to a combination of conditions. We note that the potential effects of refusal on the pregnant woman's mental health should also be taken into account in assessing risk to health.

<http://assembly.coe.int/main.asp?Link=/documents/adoptedtext/ta08/eres1607.htm> (last accessed 29 May 2015).

²⁶ See the discussion of abortion availability in Council of Europe states in *A., B. & C. v. Ireland* (2011) 53 E.H.R.R. 13, para 112.

²⁷ These include anxiety, depression and shame. See Ann Wolbert Burgess and Lynda Lytle Holstrom, "Rape trauma syndrome" (1974) *American Journal of Psychiatry* 981. Rape trauma syndrome is a form of posttraumatic stress disorder: see American Psychiatric Association, *Diagnostic and statistical manual of mental disorders* (5th ed., 2013; Washington, DC).

The risk may already have materialised at the time of assessment, or may be expected to materialise in the future.

The medical practitioners do not have to be satisfied that the abortion will completely eliminate the risk to the pregnant woman's health.

For the avoidance of doubt, the reference to 'social well-being' in the definition of 'health' in Head 2 is not an independent 'socio-economic ground' for abortion. Instead, this element of the definition allows for holistic assessment of the pregnant woman's circumstances in their full context. The medical practitioners are required to assess the woman before them, rather than reasoning from abstract categories of person or medical condition.

Medical Practitioners

We have used the term "medical practitioner" here to indicate that a GP may perform an abortion for a pregnant woman under this Head. Allowing this will safeguard timely access to early medical abortion, and can help ensure continuity of care.

We have used the term "health care practitioner" in order to facilitate the provision of care by midwives, nurses and other appropriate health workers. In these situations the registered medical practitioner has overall responsibility for the care.²⁸

Where the text refers to the opinion of "two medical practitioners", this can include the GP who performs the abortion. Given the nature of the tests to be applied, and bearing in mind the Guiding Principles under Head 3, the role of the "two medical practitioners" here and in the grounds below is to make a clinical recommendation that recognises the bodily integrity and autonomy of the pregnant woman in respect of medical decision-making. The registered medical practitioners need not meet one another in person.

We note the Labour Party's position that two medical practitioners should generally be required in order to assess a woman's entitlement to access an abortion. We have argued that the opinion of one medical practitioner should be sufficient to secure access to abortion under Head 5. There are several reasons for this:

- The current PLDPA 2013 requirement of two or three doctors is based on the existence of a constitutional right to life of the unborn. After repeal of the 8th Amendment, this justification no longer applies.
- We are concerned that a requirement of two doctors may be a source of delay given the practicalities of obtaining two doctors to offer the necessary opinion, allowing them time to consult with one another, and resolving a refusal where applicable. This will be a particular challenge where the pregnant woman lives in a rural area and a local GP holds a conscientious objection, or the pregnant woman only has access to a single-GP practice. Difficulties multiply where

²⁸ *Royal College of Nursing v. D.H.S.S.* [1981] 2 W.L.R. 279.

the pregnant woman is very young, vulnerable or unfamiliar with the Irish healthcare system, or where she has been a victim of sexual assault.

- Other European jurisdictions (e.g. Germany²⁹ and Czech Republic³⁰) allow early access to abortion on the basis of a single medical opinion, only requiring a second opinion where the pregnancy is more advanced. In other jurisdictions (e.g. Spain³¹ and Poland³²) the role of the second doctor is more limited than proposed here: it is simply to confirm the opinion of the first, rather than to offer an independent assessment of his or her own.

Code of Practice

The Code of Practice under Head 16 should make detailed provision for appropriate care pathways under this Head. In particular:

- The code of practice should detail specific care pathways with defined roles for pregnancy counsellors, schools, Gardaí, rape crisis centres and healthcare providers to persons in direct provision.
- The code of practice should make clear that when a pregnant woman requests a medical practitioner to provide an opinion under Head 5(1), he or she has a duty to promptly refer her to a second medical practitioner, so that the requirements of Head 5 can be satisfied. It is not necessary for the first medical practitioner to have arrived at a decision under Head 5(1) before making such a referral. The purpose of this positive duty of assistance is to ensure that the woman does not bear the burden of finding a second doctor, and to avoid any associated delays. This duty is subject to the requirements of Head 11 on conscientious objection. Consideration should be given to placing this duty of positive assistance on a statutory footing.
- There should be no imposed ‘waiting period’ designed to give the pregnant woman time to think about the procedure, unless she requests it. Such a requirement would be entirely inappropriate in legislation of this kind, given the seriousness of the grounds for access to abortion under this Act. Furthermore, it would be inconsistent with Head 3.
- It is not necessary that both registered medical practitioners physically examine the pregnant women. The second practitioner should be able to make a decision based on medical records and referral from the first. Repeated examinations may generate unnecessary burdens on a pregnant woman’s privacy, and may also produce delays in accessing treatment.

²⁹ See Pregnancy and Family Assistance Law from 27 July 1992, amended by *Schwangeren und Familienhilfeänderungsgesetz* BGBl 1995, I, 1050-57 following Bundesverfassungsgericht, Zweiter Senat, Urteil vom 28 Mai 1993, 2 BVFG 2/90; 2 BVFG 4/92; 2 BVFG 5/92; NJW, Heft 26. 1751, 1993.

³⁰ Law 66 and Regulation 75, 1986, effective 1 January 1987; Regulation from the Ministry of Health 467/1992.

³¹ Organic Law 9/1985 of 5 July 1985; Crown Decree 2409/1986 of 21 November 1986; Order of 16 June 1986; Organic Law 10/1995 of 23 November 1995.

³² Law on Family Planning, Human Embryo Protection and Conditions of Abortion, 7 January 1993 (as amended).

- Both medical and surgical abortions should be available under this ground, and, in line with Head 3, the wishes of the pregnant woman should be the primary consideration in determining which method is used.
- Medical practitioners should be able to both prescribe and dispense pills for early medical abortion.
- For reasons of safety, guidance for doctors should recommend that the pregnant woman be entitled to take early medical abortion pills at home, particularly where there is a significant travel time between her home and the GP's office.³³
- Medical practitioners should be obliged to provide or arrange non-directive counselling for pregnant women who request it.

Rape

We have not proposed an independent ground of abortion on the basis of a pregnancy resulting from rape or sexual crime under this Act. It is important to avoid exposing pregnant women to damaging engagement with the criminal justice system or the police, which might lead to delay in access to healthcare, or to further degradation and distress.³⁴ For similar reasons, there should be no requirement that women who have been subjected to sexual assault are subjected to distinctive (and in any case ineffective) medical examinations as a precursor to accessing abortion care.

Under the model proposed here, women whose pregnancies result from rape and sexual violence will be required to access abortion under the health grounds. The position of women who have been raped should be borne in mind in the interpretation of Heads 5 and 6, in order to ensure that the necessity of framing the woman's entitlement to access abortion in health terms does not generate undue obstacles to access to health-preserving medical treatment. In particular, account should be taken of the impact of refusal of treatment, and continuation of a non-voluntary pregnancy on the woman's mental and physical health.³⁵

³³ See further Thoi Ngo, Min Hae Park, Hakeema Shakur, Caroline Free, "Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review" (2011) 89(1). *Bulletin of the World Health Organisation* 360-70.; Yael Swica, Erica Chong, Tamer Middleton, Linda Prine, Marji Gold, Courtney A. Schreiber, Beverly Winikoff, "Acceptability of home use of mifepristone for medical abortion" (2013) 88 *Contraception* 122-27.

³⁴ Ireland has one of the lowest conviction rates for rape in Europe: Jo Lovett and Liz Kelly, "Different systems similar outcomes? Tracking attrition in reported rape cases across Europe" (2009, London Metropolitan University). The *Rape and Justice in Ireland* study found that rape cases dropped out of the criminal justice system for a number of reasons, including: victims' fear of not being believed by the Gardai; victims' sense of frustration and alienation with the criminal process; and the effect of unfounded stereotypes about men and women wrongly influencing jurors hearing cases. See Conor Hanly, Deirdre Healy and Stacey Scriver, *Rape and Justice in Ireland* (2009, Rape Crisis Network Ireland). Furthermore, research indicates that the majority of rapes are committed by current or ex partners: Lovett and Kelly at 75-76. Women in that situation are particularly vulnerable and involvement of the criminal justice system could be especially damaging.

³⁵ The UNHRC has argued that when a woman who is pregnant as a result of rape is denied a termination, "this situation entails constant exposure to the violation committed against her and causes serious traumatic stress and a risk of long-lasting psychological problems such as anxiety and depression": Conclusions and Recommendations of the Committee Against Torture, U.N. Doc. CAT/C/NIC/CO/1 (2009). See also UN Committee Against Torture, 'Consideration of Reports

We strongly encourage the Labour Party to invite submissions from appropriate rape crisis support bodies and survivor support groups to verify the validity of this approach in an Irish context.

Broader Issues of Access to Care

We note that pregnant women's rights to access healthcare are compromised where they are asked to pay excessive treatment fees. When medical treatment is not affordable, women may be driven to access unsafe illegal abortions, or to take other risks with their health. Thus, the cost of treatment and prescriptions should be maintained at reasonable levels, and should not vary widely from provider to provider. Those entitled to medical cards should have the treatment provided under this Act covered by the medical card. Private health insurance providers should be obliged to cover the costs of abortion.³⁶

The Act may need to make further provision for pharmacists to dispense medications prescribed for early medical abortion.

Head 6: Risk of Severe or Disabling Damage to Health

Provide that:

1. An abortion may be performed by a registered medical practitioner, or other health care practitioners under their supervision, until the twenty-fourth week of pregnancy if:
 - a. Two registered medical practitioners are of the opinion, formed in good faith, that the continuance of the pregnancy would entail a risk of severe or disabling damage to the pregnant woman's health; and
 - b. The abortion is performed at an authorised location; and
 - c. In forming their opinions, both registered medical practitioners have taken account of the pregnant woman's views on the impact of the continuance of the pregnancy on her health.

Explanatory note

The definition of 'health' here is the same as under Head 5, as outlined in the interpretive provision of Head 2, and in that respect the explanatory notes to Head 5 apply here also. The key distinction between the two grounds lies in the seriousness of the health condition in question. However, for the reasons outlined under Head 5, we

Submitted by States Parties under Article 19 of the Convention: Concluding Observations of the Committee Against Torture: Nicaragua', U.N. Doc. CAT/C/NIC/CO/1, June 10, 2009, para. 16.

³⁶ It is the norm across Europe that health insurance providers must cover medical/therapeutic abortion. See practice in e.g. Poland, Slovakia, the Netherlands, UK outlined in International Planned Parenthood Federation, *Abortion Legislation in Europe* (2009). Available at https://www.ifpa.ie/sites/default/files/documents/resources/ippf_abortion_legislation_in_europe_feb_2009.pdf (last accessed 29 May 2015).

caution against overly rigid interpretation and offer the following points of clarification, which should be included in the Head 16 Code of Practice.

- “Severe damage” must be assessed holistically in light of the statutory definition of health. Accordingly, for example, what might not be considered “severe damage” to one woman’s health, might amount to “severe damage” to another’s when familial responsibilities, medical history or social circumstances are taken into account.
- “Severe damage” to a person’s health might also encompass restrictions on one’s ability to manage an existing serious health condition e.g. inability to take particular medication while pregnant.
- ‘Disability’ here refers to impairment of physical, mental or social functioning. The pregnant woman need not be at risk of permanent or severe long-term disability. A shorter period of severe disability may be sufficient, even if rehabilitation as possible e.g. as might occur with a stroke.
- We note, again, the absence of a separate ‘rape ground’, and the consequences for interpretation of the health grounds. Serious psychiatric risks post-rape are clearly covered by this ground.
- The existence of this ground should also be read as removing any residual uncertainty about the entitlement to access abortion on grounds that the pregnancy poses a risk to life (Head 7 below). “Severe damage” to health should encompass a serious illness that may become life-threatening, allowing doctors to act before the pregnant woman’s health deteriorates to the extent that her life is clearly at risk.³⁷

The Commission spent some time in deliberating over the question of time limits. The legal expert group advises against the use of the word ‘viability’ to indicate a ‘cut off point’ for access to abortion under this ground. No other European jurisdiction uses this term in the context of an equivalent ground for access to abortion. Either legislation does not impose any time limit at all or it specifies a time limit in number of weeks (usually 24).³⁸

The ‘no time limits’ approach is justified by reference to the severity of the health risks to which the woman is exposed, which may require that abortion should be an available option until late into the pregnancy. In any future Irish abortion legislation, there is a strong case for setting time limits aside when the woman is at risk of grave disability or ill-health.

³⁷ See Concluding Observations of the Committee Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), 46th session, 17 June 2011, U.N. Doc. CAT/C/IRL/CO/1, at para. 26. See also *K.L. v. Peru* (2005), Comm. No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 holding that placing the pregnant girl’s life in danger was also a breach of the right to life.

³⁸ See, for example, the law in Austria (up to end of second trimester: Federal Law 23 January 1974 (Bundesgesetzblatt, No. 60, 1974)), Belgium (no time limit: Law on Termination of Pregnancy, 3 April 1990), Denmark (up to end of second trimester: Act No. 350, 13 June 1973. Amended through Law No. 389, 14 June 1995 and L.B.K. No. 95 07/02/2008), France (no time limit: Law No. 588, 2001), and the United Kingdom (no time limit: Abortion Act 1967).

The ‘number of weeks’ approach adopted here is justified by reference to legal certainty: it is important that politicised medical debates over when ‘viability’ begins are not permitted to restrict pregnant women’s statutory entitlements. The medical group has advised that ‘viability’ should not be defined solely by reference to a set number of weeks of gestation since birth weight, in particular, may be an important factor in determining viability in any particular circumstance. However, we want to emphasise the importance of clarity in the law, particularly for pregnant women’s understanding of their entitlements, and for doctors’ ability to interpret the law with confidence.

Head 7: Risk to Life

Provide that:

1. An abortion may be performed by a registered medical practitioner, or other health care practitioners under their supervision, if:
 - a. Two registered medical practitioners are of the opinion, formed in good faith, that the continuance of the pregnancy would entail a risk to the life of the pregnant woman; and
 - b. The abortion is performed at an authorised location; and
 - c. In forming their opinions, both registered medical practitioners have taken account of the pregnant woman’s assessment of the potential risk to her life.
2. “Risk to life” includes the risk of suicide.

Explanatory note

This Head is necessary to maintain the entitlement to a life-saving abortion after repeal of the PLDPA 2013.

Bearing in mind the Guiding Principles under Head 3, this Act does not distinguish between physical risks to life and risk of suicide.

Given the severity of the risk to which the woman is exposed, there can be no time limit imposed on access to abortion under this ground. This is already the case under the PLDPA 2013.

As with other Heads, the woman’s wishes should be of primary importance in selecting the method of abortion adopted.

Head 8: Fatal Foetal Anomaly

Provide that:

1. An abortion may be performed by a registered medical practitioner, or other health care practitioners under their supervision, if:

- a. Two registered medical practitioners are of the opinion, formed in good faith, that the foetus suffers from such anomaly or injury that:
 - i. It is unlikely to be born alive; or
 - ii. It is likely to die during birth; or
 - iii. It is unlikely to be capable of sustaining independent life after birth; and
- b. The abortion is performed at an authorised location.

Explanatory note

The reference to “anomaly or injury” is intended to clarify that this section focuses on the outcome for the foetus, rather than on the origin of the foetus’s condition.

It is most likely that the “registered medical practitioners” operating under this Head will be obstetricians, who may seek the opinion of an expert in maternal-foetal medicine in cases of doubt.

We note that, in certain circumstances, the prospect of continuing with a pregnancy falling under this Head will have such a severe impact on the pregnant woman’s health that it will be possible to proceed under Head 6 or 7.³⁹ However, the Terminations for Medical Reasons Ireland (TFMRI) campaign seems to suggest that many women’s preference is for an independent ground and, unlike the rape ground considered above, there are no significant countervailing issues.

We urge that consideration be given to extending this ground to allow termination of pregnancy where the foetus suffers from a serious and incurable condition of such severity that the accepted course of medical treatment would be to withdraw life-preserving medical treatment in the best interests of the neonate, with the consent of the parents. Such a provision would also avoid the development of unnecessary ‘chilling effects’ in circumstances in which the foetal abnormality is not likely to be immediately fatal.

Abortions under Head 8 should be carried out in a hospital equipped to provide appropriate services e.g. post mortem services after delivery.

As with other Heads, the woman’s wishes should be of primary importance in selecting the method of abortion adopted.⁴⁰ We note the particular challenges which

³⁹ See *K.L. v. Peru* (2005), Comm. No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 in which the UNHRC found that compelling an adolescent to continue with a pregnancy when her foetus had been diagnosed as anencephalic amounted to inhuman and degrading treatment.

⁴⁰ The Royal College of Obstetrics and Gynecology, *Guidelines on Termination of Pregnancy for Foetal Abnormality in England, Scotland and Wales* (2010) recommend that foeticide should be routinely offered as part of abortion of 21+ weeks of gestation. The *Guidelines* acknowledge that some women may prefer termination without prior foeticide and recommend that, in such instances, delivery management should be planned with the parents and all health professionals involved, appropriate counseling provided, and a care plan agreed before the termination of pregnancy takes place. Available at <https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf> (last accessed 30 May 2015).

will be experienced by many women in coping with labour in the context of induced medical abortion.

Head 9: Emergency

Provide that:

1. Notwithstanding the provisions of Heads 5 to 8, it shall be lawful for a single registered medical practitioner to perform an abortion on a pregnant woman if he is of the opinion, formed in good faith, that the abortion is necessary to avoid an immediate risk to her life, or an immediate risk of severe or disabling damage to her health.

Head 10: Consent

Provide that:

1. Nothing in this Act shall operate to affect any enactment or rule of law relating to consent to medical treatment.

Explanatory note

The effect of this section is to ensure that the law of consent applies to abortion in the same way as to any other medical treatment, so that no competent pregnant woman may be subjected to any medical procedure without her consent.⁴¹

Appendix 10 to the PLDPA Implementation Guidelines⁴² gives an account of the law of consent as it interacts with the current law on abortion. We note that the stated position in relation to decision-making capacity will no longer hold once the Assisted Decision-making (Capacity) Bill 2013 passes into law. In particular, the assertion in the current Guidance that “in making decisions for those who lack capacity, the responsible clinician should determine what is in their best interests”⁴³ will not survive the enactment of the Assisted Decision-making (Capacity) Bill. Among the

⁴¹ There is a dearth of reported cases on pregnant women’s right to withhold consent to medical treatment in Ireland. The *National Consent Policy* currently states that, due to the 8th Amendment, there is currently significant legal uncertainty about the extent to which a pregnant woman can refuse treatment in circumstances that would put the life of a viable foetus at serious risk. Health Service Executive, *National Consent Policy* (2014). Available at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/National_Consent_Policy/consenttrainerresource/trainerfiles/NationalConsentPolicyM2014.pdf (last accessed 22 May 2015). Following the repeal of the 8th Amendment, that legal uncertainty should be substantially resolved. On pregnant women’s experiences around informed consent and refusal in Irish obstetric care more generally see AIMS Ireland, *What Matters to You?* <http://aimsireland.ie/breaking-news-aims-ireland-release-survey-result-from-nearly-3000-women-on-issue-of-consent-in-maternity-care-wmt2014/> (last accessed 29 May 2015).

⁴² Department of Health, *Implementation of the Protection of Life During Pregnancy Act 2013: Guidance Document for Health Professionals* (2014).

⁴³ *Ibid*, Appendix 10.

changes of direct relevance to this legislation are the removal of the ‘best interests’ standard for decision-making for people lacking capacity and its replacement with a standard based on a set of guiding principles.⁴⁴ A key aspect of these principles is that the person making the decision must “permit, encourage and facilitate” the person lacking capacity to participate as “fully as possible in the intervention” and that any decision made must give effect “as far as practicable” to the “past and present will and preferences” of the person and take into account the person’s beliefs and values insofar as these are reasonably ascertainable. Other key elements of the legislation are the proposed introduction of provision for assisted decision-making, whereby a person with capacity difficulties may appoint a decision-making assistant to help them in making decisions,⁴⁵ or co-decision-making where a person may appoint a co-decision-maker to make decisions with them.⁴⁶ The intention of this Head is to ensure that these provisions will apply in respect of this legislation.

In respect of young people under the age of 18 years, s. 23 of the Non-Fatal Offences against the Person Act 1997 states that the consent of a 16 year old is as effective as if she were of full age. The position with young people under the age of 16 remains unclear, and the applicability of the ‘Gillick competence’ test⁴⁷ in Ireland is still uncertain.⁴⁸ However, a maturity-based decision-making standard is consistent with the requirements under Art. 12 of the Convention on the Rights of the Child (CRC) by which the State is bound. Therefore a strong case may be made that, should the matter come before the courts, some form of maturity-based approach to decision-making will be adopted. The Law Reform Commission has followed international human rights law (most notably the CRC) to recommend that “in the context of health care provision, the law should respect the evolving capacity of individuals under the age of 16, with the aim of promoting access to necessary medical treatment”.⁴⁹ The intention of this Head is to ensure that any developments in this area (whether legislative or judicial) apply in respect of this legislation.

Part 4: Refusal of Access to Abortion Care

Head 11: Refusal of Care on Grounds of Conscience

Provide that:

1. Medical professionals, or other health care practitioners under their supervision, may refuse to participate in an abortion on the basis of a good faith conscientious objection, except where the abortion is immediately necessary to save the pregnant woman’s life or to prevent severe or disabling damage to her health.
2. A person who has a conscientious objection shall without delay (i) inform the pregnant woman of the refusal of care in writing (ii) inform her of her right to

⁴⁴ Assisted Decision-making (Capacity) Bill 2013 s. 8 (as initiated).

⁴⁵ Assisted Decision-making (Capacity) Bill 2013 s. 11 (as initiated).

⁴⁶ Assisted Decision-making (Capacity) Bill 2013 s. 21 (as initiated).

⁴⁷ *Gillick v. West Norfolk & Wisbeck Area Health Authority* [1986] A.C. 112

⁴⁸ *H.S.E. v. J.M. and Anor* [2013] IEHC 12

⁴⁹ Law Reform Commission, *Children and the Law: Medical Treatment* (2009, Dublin), p. 83.

- see an alternative medical practitioner, nurse or midwife and (iii) make such arrangements for the transfer of her care as are necessary to enable her to access an abortion in a timely manner.
3. Health care institutions may not invoke a right to conscientious objection under this Head.
 4. The Minister for Health retains the responsibility of ensuring that a safe and timely service is maintained for patients when accommodating conscientious objectors. In particular, it shall ensure that all authorised locations under Heads 6-8 have at their disposal the means enabling them to perform abortions under this Act.
 5. In any legal proceedings arising from this Head, the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

Explanatory note

The Act treats conscientious objection as a matter for individual practitioners only and not for institutional health care providers. There is no internationally recognised institutional right of conscientious objection.⁵⁰

There is no individual right of conscientious objection in emergency circumstances. As set out in Head 9, ‘emergency’ includes immediate risk of developing a serious health condition as well as immediate risk to life. In this, the Act mirrors the PLDPA 2013.

The term “participate” is taken here to apply to personnel who are directly involved in performing or authorising the abortion. Those providing ancillary care (e.g. who attend to, nurse or treat the woman before or after the abortion, or who make arrangements for such care) have no right to conscientious objection.⁵¹

Nothing in the right to conscientious objection shall be taken to impact on a patient’s entitlement to receive objective, non-judgemental, and non-discriminatory medical advice and treatment.

The Minister for Health bears final responsibility for ensuring that assertion of conscientious objection does not lead to delays that compromise pregnant women’s access to abortion.⁵² This extends to ensuring that sufficient medics who do not hold conscientious objections, and who are trained to provide abortion care, are available in authorised locations.⁵³ The Minister may also wish to ensure that women can

⁵⁰ See CEDAW, Concluding Observations on the Combined Seventh and 8th Reports of Hungary adopted by the Committee at its fifty-fourth session, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013).

⁵¹ For further discussion on this point see *Greater Glasgow Health Board v. Doogan & Anor* (Scotland) [2014] U.K.S.C. 68.

⁵² See *R.R. v. Poland* [2011] E.C.H.R. 828, *P. and S. v. Poland* App. No. 57375/08, 30 October 2012 arguing that a woman’s ECHR rights are breached where conscientious objection leads to significant delays in accessing legally available medical treatment.

⁵³ The State is obliged to ensure that individual rights are properly vindicated within institutions under its control. See *O’Keeffe v. Ireland* [2014] E.C.H.R. 96. See similarly *da Silva Pimentel v. Brazil*, Communication 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (CEDAW, July 25, 2011). In particular, the State must ensure that sufficient doctors who do not hold conscientious objection to secure

access, and be reimbursed for accessing, appropriate private healthcare where they are refused access to abortion care in a public facility.⁵⁴

Code of Practice

In respect of conscientious objection, the Code of Practice required under Head 16 should provide that:

- Where a doctor is refusing to provide an opinion under Heads 5-8 on conscientious grounds, he should inform the pregnant woman of this immediately, and should make clear that his refusal to treat is not an ordinary refusal under the Act.
- Where a fee has been paid to a GP who then refuses to consider a woman's entitlement to an abortion on conscientious grounds, the fee should be transferred to an alternative doctor upon referral.
- The holder of a medical card should not be required to attend her ordinary GP for abortion care if she prefers to attend a different doctor. This is already the position with family planning care.⁵⁵
- Conscientious objection should be expressed to the pregnant woman in a way that limits any possibility of confrontation, distress, exploitation of vulnerability or re-enforcement of abortion stigma. The Code of Practice should take account of international best practice in this regard.
- Those asserting a conscientious objection must bear some obligation of disclosure in order that the Department of Health can ensure that there is sufficient staff willing and able to provide abortion care available in each hospital. For instance, those asserting a conscientious objection might be required to submit a detailed written explanation to the appropriate authority within their place of employment, in the event that they are unable to provide care to a pregnant woman under Head 11. An arrangement of this kind is in force in Poland.⁵⁶ Alternatively, individuals might be required to disclose conscientious objections in advance to their employing hospital, whether before the Act comes into force, or at the point of employment. In designing this requirement, due regard should be had to the individual's rights to privacy and freedom of conscience and religion.

women's access to abortion are available in each hospital/geographical area. See *R.R. v. Poland* [2011] E.C.H.R. 828, *P. and S. v. Poland* App. No. 57375/08, 30 October 2012 and *International Planned Parenthood Federation European Network v. Italy*, Complaint No. 87/2012, Decision of the European Committee of Social Rights of 10 September 2013.

⁵⁴ See Spain's Royal Decree 831.

⁵⁵ Family Planning Policy: Guidelines for Health Boards (1995), p. 9. Available at <http://www.lenus.ie/hse/bitstream/10147/251197/1/FamilyPlanningPolicyGuidelinesForHealthBoards.pdf> (last accessed 4 June 2015).

⁵⁶ *P. and S. v. Poland* App. No. 57375/08, 30 October 2012, para. 107.

Head 12: Establishment of Review Body**Provide that:**

1. On the establishment day there shall stand established a Review Body which shall perform the functions conferred on it by this Act.
2. The Review Body shall be independent in the exercise of its functions.
3. The Chair of the Review Body shall, as soon as may be, establish and maintain a national panel of 15 individuals to serve as tribunal members.
4. These shall be appointed through the public appointments process. Of the members of the panel, at least half shall be women.
5. The national panel of tribunal members shall comprise of 5 barristers or solicitors of at least 7 years' practice experience, 5 medical practitioners of relevant specialisms, and 5 other persons.
6. Applicants for these positions shall be required to disclose (i) any conscientious objection to the provision of abortion care; and (ii) any potential conflict between their other duties or interests, and their duties or interests as a member of the tribunal.
7. No applicant shall be appointed to the national panel who, in the opinion of the Chair of the Review Body, is incapable of discharging the functions of a tribunal member by reason of a conscientious objection or conflict of interest under (6) above.
8. The Review Body shall furnish, whenever it so thinks fit or is so requested by the Minister for Health, advice to the Minister on any matter connected with its functions or activities.
9. The Minister for Health shall prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the Review Body.

Head 13: Application for Review**Provide that:**

1. Where a registered medical practitioner is of the opinion that a pregnant woman is not entitled to undergo an abortion under Heads 5-9, he or she shall immediately
 - a. Inform her of that refusal, providing written confirmation within 24 hours; and
 - b. Inform her of her right to make an application to a Review Tribunal under sub-head 2 below, and
 - c. Inform her of her right to seek a second opinion. If the pregnant woman prefers to seek a second opinion, the registered medical practitioner shall refer her to an alternative practitioner without delay.
2. Upon refusal, the pregnant woman, or a person acting on her behalf, may make an application in the prescribed form and manner to the Chair of the Review Body for review of the decision.

Head 14: Proceedings of Review Tribunal**Provide that:**

1. A tribunal shall consist of 3 members:
2. Of the members of the tribunal
 - a. One shall be a practising barrister or solicitor of 7 years' practice experience, who shall be the Chairperson of the tribunal.
 - b. One shall be a medical practitioner of a relevant specialism.
 - c. One shall be neither a person referred to in paragraphs (a) or (b), nor a registered medical practitioner or a registered nurse.
 - d. None shall previously have been involved in the pregnant woman's medical treatment.
 - e. All shall be members of the national panel established in accordance with Head 12.
3. The tribunal shall have such powers as are necessary for the timely completion of its functions including, the power to compel appearance of witnesses and to examine and cross-examine them; the power to take written evidence and the power to order remedial action, including a positive order that a requested abortion be performed at a designated time and location.
4. The pregnant woman shall be given the opportunity to make her views known to the tribunal, either in writing or verbally, unless she does not wish to do so.
5. The pregnant woman shall not be required to attend before the tribunal unless she wishes to do so.
6. The pregnant woman shall be entitled to legal representation, and to an assisted decision-maker if desired. She shall be entitled to represent herself if she wishes.
7. The pregnant woman shall be entitled to an interpreter or translator if required.
8. At a sitting of a tribunal, each member shall have a vote and every question shall be determined by a majority of the votes of the members.
9. Tribunal proceedings should be conducted in a non-adversarial manner, since there are no opposing parties.
10. The tribunal shall reach a decision as soon as may be, but in any event not later than 72 hours from receipt, by the Tribunal, of the application for review.
11. The tribunal shall communicate its decision to the pregnant woman in writing as soon as may be, but in any event not later than 72 hours from receipt, by the Tribunal, of the application for review.
12. The tribunal shall issue an anonymised written record of its decision, and shall cause it to be forwarded to the Minister within 28 days of that decision.
13. There shall be a direct right of appeal to the High Court from decisions of the tribunal.
14. The Minister shall make detailed regulations in relation to the practice and procedure to be adopted for the reception, storage, prohibition of onward transmission and destruction of the records generated by the Tribunal, in order to ensure pregnant women's privacy and protect the confidentiality of their data.

Explanatory note

The Review Body provides a procedural safeguard to ensure that the law is applied properly.⁵⁷ The model proposed is based on that under the Mental Health Act 2001, and is designed to remove some of the unnecessary and harmful sources of uncertainty which form part of the PLDPA 2013 appeals mechanism.

Wrongful refusals, which do not proceed to review, can be dealt with after the fact by ordinary disciplinary proceedings, or by court proceedings.

The tribunals are not composed solely of doctors. This is because the purpose of review is to assess whether the law has been applied correctly to the medical facts of each case, as well as to determine whether those facts have been properly evaluated. Additional medical expertise can be obtained by calling appropriate experts to advise the tribunal if necessary.

There is some concern that individuals with a political interest in undermining new abortion legislation could be appointed to such tribunals. The obligation to declare a conflict of interest, or any relevant conscientious objection, is directed to addressing this problem. In addition, we note that the tribunals would be subject to ordinary principles of administrative law, including the rule against bias, by means of judicial review.

The maximum time limit of 72 hours is shorter than the 7 days presently allowed for under the PLDPA 2013.⁵⁸ Tribunal proceedings should be held more quickly where possible. This is appropriate given the effects of unnecessary delay on access to abortion.

Every effort should be made to provide additional support for pregnant women who are very young, otherwise vulnerable, or whose first language is not English, to ensure that they have effective access to the review process. In particular, a pregnant woman should be entitled to bring a friend or support person to the tribunal with her, if she chooses to attend.

The Department should consider making appropriately redacted records of tribunal decisions publicly available, for the purpose of guiding doctors in future cases.

There is no right to review of a positive decision under Heads 5-9.

For the avoidance of doubt, no third party (e.g. the genetic father of a foetus) may bring an application for a review on their own behalf.

There should be no fee for use of the review procedure, and the pregnant woman should be entitled to civil legal aid in respect of legal advice or legal representation sought for the purposes of participating in the review. Arrangements should be made

⁵⁷ *Tysiqc v. Poland* [2007] E.C.H.R. 219, para. 66.

⁵⁸ s. 13, Protection of Life During Pregnancy Act 2013.

to ensure that an application for legal aid for this purpose is automatically considered 'meritorious', and that applications are expedited (as they are in childcare applications).

Part 5: Protection of Pregnant Women Seeking Treatment and Service Providers

Head 15: Prohibited Behaviour Outside Premises

Provide that:

1. A person must not engage in prohibited behaviour within a radius of 100 metres from the perimeter of any premises at which abortions are provided.
2. In this section "prohibited behaviour" means
 - a. In relation to a person, besetting, harassing, intimidating, interfering with, threatening, hindering, intimidating, obstructing or impeding that person; or
 - b. A protest in relation to terminations that is able to be seen or heard by a person accessing, or attempting to access, premises at which abortions are provided; or
 - c. Footpath interference in relation to abortions; or
 - d. Intentionally recording, by any means, a person accessing or attempting to access premises at which abortions are provided without that person's consent, or publishing or distributing a recording so obtained (An exception to this provision should apply to a garda making a recording in the course of duty.)
3. Conviction for the offence of engaging in prohibited behaviour under this section shall carry a penalty of a fine not exceeding €2500 or imprisonment for a term not exceeding 12 months, or both.
4. All necessary Garda powers of detention and seizure are hereby provided for.

Explanatory note

The purpose of this Head is to prohibit individuals from preventing or attempting to prevent legal abortions from taking place, whether their behaviour is intended to do so or simply has such an effect. Bearing in mind recent events in Britain⁵⁹ and Northern Ireland,⁶⁰ we suggest that this provision is necessary to protect women's right to privacy, to criminalise and deter unreasonable interference with pregnant women's

⁵⁹ See, for example, Chi Chi Izundu, "Call for law to stop anti-abortion protests outside clinics", BBC Newsbeat, 28 November 2014. Available at <http://www.bbc.co.uk/newsbeat/30126873> (last accessed 30 May 2015).

⁶⁰ See for example Amanda Ferguson, "Bernie Smyth cautioned after protest outside Marie Stopes Centre in Belfast", *The Belfast Telegraph*, 19 December 2014. Available at <http://www.belfasttelegraph.co.uk/news/local-national/northern-ireland/bernie-smyth-cautioned-after-protest-outside-marie-stopes-centre-in-belfast-30850430.html> (last accessed 30 May 2015).

statutory right of access to abortion care, and to undermine the stigmatisation of service providers working in the areas of sexual and reproductive health.⁶¹

The right of states to impose geographical restrictions on protests has been upheld by the European Court of Human Rights.⁶² While the context of abortion protests has not been specifically addressed by the Court we are confident that, given the competing rights to privacy and family life of the pregnant person which arise in that context, the Court would maintain that approach and find such a provision to be a proportionate and justifiable limitation of Article 10 and 11 rights.

Part 6: General

Head 16: Code of Practice

Provide that:

1. The Minister for Health shall cause to be prepared, after consultation with such bodies as he considers appropriate, a code or codes of practice for medical practitioners working in abortion care.
2. The Minister shall, not later than 2 years after the date on which the Act is enacted, and again not later than 5 years after that date, carry out a review of the operation of this Code of Practice assessing, in particular, its consistency with international best practice in the field of abortion care and its compliance with national, regional and international equality and human rights standards, and shall make a report to each House of the Oireachtas of his or her findings and conclusions resulting from the review.

Explanatory note

We have suggested content for the Code of Practice throughout the Explanatory Notes to these Draft Heads of Bill.

We note that the Implementation Guidelines to the Protection of Life During Pregnancy Act 2013⁶³ were not published until some months after the Act came into force. In order to avoid confusion around the proper interpretation of the Act, the Act and its accompanying Code should be published simultaneously.

The Code of Practice should include precise recommended timelines for care under each of Heads 5-9. In particular, women should be offered an assessment within five days of making a request for an abortion under Head 5 and at a maximum within two weeks of that request. Ideally, a woman can undergo the abortion within 7 days of

⁶¹ See further Report of the Special Rapporteur on Human Rights Defenders Mission to Ireland 2012. Available at http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A-HRC-22-47-Add-3_en.pdf (last accessed 29 May 2015).

⁶² *Ziliberg v. Moldova* (App 61821/00) Inadmissible, 04 May 2004 where the Court declared an application that such restrictions were a breach of the right to assembly was not admissible.

⁶³ Department of Health, *Implementation of the Protection of Life During Pregnancy Act 2013: Guidance Document for Health Professionals* (2014).

receiving two positive medical opinions under Heads 5-8. She should not have to wait longer than 3 weeks from her initial request to the time of her abortion. Referral should be expedited where the woman's pregnancy is approaching 12 (Head 5) or 24 (Head 6) weeks, or where she is requesting an abortion under any of the other grounds. Medical practitioners should, as part of their training, be made aware of the reasons why pregnant women can delay in presenting for assessment.

The bodies consulted under Head 16 should not be confined to medical and healthcare bodies. In particular, they should include service providers involved in abortion care and associated fields, as well as the Irish Human Rights and Equality Commission.

We caution against the assumption that the bulk of the detail of abortion care regulation is best left to a non-statutory code of practice. It is important that all regulations governing women's constitutionally protected access to abortion care are subjected to public scrutiny. It is also crucial that all procedural and substantive safeguards necessary to enable that access are placed on a statutory footing, particularly if women are to be empowered to challenge unjustified refusal or restriction of abortion care once the legislation is in force.

We have not included an equivalent to s. 21 of the PLDPA 2013.⁶⁴ If the Minister has the power to suspend the provision of abortions in any circumstances, pregnant women's right to access to healthcare is likely to be compromised.⁶⁵

Head 17: Reporting and Notification

Provide that:

1. Where a medical practitioner performs an abortion he or she shall
 - a. Keep a record in the prescribed form and containing the prescribed information and
 - b. Not later than 28 days after the abortion has been carried out, forward that record to the Minister for Health.
2. Such record should not include any information capable of identifying the pregnant woman for whom the abortion has been performed.
3. The Minister for Health shall, not later than 30 June each year, prepare a statistical report on records forwarded under s. (1)(b), and decisions of the tribunals under Head 14 received in the preceding year. The Minister shall, as soon as may be, cause the report to be laid before the Houses of the Oireachtas.
4. The Minister shall make detailed regulations in relation to the practice and procedure to be adopted for the reception, storage, prohibition of onward

⁶⁴ Providing for suspension of abortion care in specified locations by Ministerial notice.

⁶⁵ See Irish Human Rights Commission, *Observations on the Protection of Life During Pregnancy Bill* 2013 (2013, Dublin), pp. 41-42. Available at http://www.ihrec.ie/download/pdf/ihrc_observations_protection_of_life_in_pregnancy_bill_2013.pdf (last accessed 29 May 2015).

transmission and destruction of the records at (1) above, in order to ensure pregnant women's privacy and protect the confidentiality of their data.

Explanatory note

The recommendation on reporting under Head 17 follows the model of the PLDPA 2013.⁶⁶ This model does not require reporting of refusals. We suggest that, at least in the early years of the operation of the Act, some official statistical record should also be kept of abortions refused, so that the progress of the legislation can be evaluated.

The protection of pregnant women's confidential data will be central to the reporting process under Head 17, particularly given the on-going stigmatisation of women who require abortions. As a data protection model under Head 17, we recommend that set out in Spain's Organic Law 2-2010 of March 3 on Sexual and Reproductive Health and Voluntary Termination of Pregnancy.⁶⁷

Head 18: Information

1. The Minister for Health shall take such steps as are necessary to guarantee that pregnant women are able to access relevant, full and reliable information on their entitlements under this Act.⁶⁸
2. The Minister for Health shall be empowered to adopt regulations governing the conduct of pregnancy counselling agencies. In particular, the Minister shall adopt regulations to prohibit the withholding or misrepresentation of health-related information by medical practitioners or other persons discharging statutory responsibilities under this Act.

Additional Recommendations

Criminal Offences

With s. 22 of the PLDPA 2013 repealed, there will no longer be any offence of intentional destruction of unborn life. We do not propose to replace this offence. However, as the law stands, it may be advisable to make some provision within the Non-Fatal Offences against the Person Act 1997 (NFOAPA) to recognise the specific harm done to a pregnant woman when she is assaulted and the assault results in miscarriage.

We suggest that in order to achieve this, the term "causing a woman to miscarry" be added to the existing definition of assault causing "serious harm" (amending s.1 of

⁶⁶ s. 20, Protection of Life During Pregnancy Act 2013.

⁶⁷ Translated at

<http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Organic%20law%202010%20on%20SRH%20and%20voluntary%20pregnancy%20termination%20-%20English%20Translation.pdf>.

⁶⁸ See e.g. *Family Planning Association of Northern Ireland v. Minister for Health, Social Services and Public Safety* [2004] N.I.C.A. 39.

NFOAPA to apply to s.4). This offence would apply even where no additional harm had been done to the womb itself. The maximum penalty would be life imprisonment.

Such an amendment would make causing a woman to miscarry part of the definition of “serious harm”. We envisage that such a provision section would deal with domestic violence resulting in miscarriage, violence against women more generally, and abortions performed by unskilled and unregulated individuals (e.g. ‘back street’ abortions). It is impossible to exclude the application of the amended s. 4 to those doctors who perform abortions outside the terms of this Act in good faith. This is because it is not possible for a woman to consent to an assault causing harm.⁶⁹

As noted above, persons who supply an abortion pill to a pregnant woman will be guilty of regulatory offences under the Prescription Regulations.⁷⁰ If they import the pill they will be liable for regulatory customs and excise offences.

Where a person supplies a medication such as misoprostol or mifepristone to a pregnant woman, who then takes it voluntarily, that person will not be liable for constructive voluntary manslaughter following the repeal of the 8th Amendment. However, if a baby is subsequently born who then dies as a result of complications arising out of the administration of the abortion pill, a prosecution for gross negligence manslaughter would be possible. There is a question about whether someone who supplied the abortion pill to a pregnant woman who then takes it voluntarily would be liable for a s. 4 assault causing harm under the NFOAPA. We are of the view that such people would not be liable for s. 4 assault because the chain of causation would have been broken by the woman’s decision to take the pill. This is the position in relation to poisoning offences under the Non Fatal Offences against the Person Act (see below) and it is the position in England and Wales⁷¹ in situations where a person facilitates another to inject an illegal drug. The Law Reform Commission agrees with this approach to manslaughter following injection of drugs by the victim.⁷² We submit that such an approach should also be adopted in respect of the supply of the abortion pill.

Mens Rea

The proposed offence treats causing a miscarriage as equivalent to other serious but non-fatal harm. The offence would require proof of intention, although the intention would be to cause serious harm, not necessarily to cause a miscarriage. Where this cannot be established, assault causing harm under s.3 could be prosecuted; however, doing so would not recognise the additional harm of the miscarriage.

⁶⁹ *R. v. Brown* [1984] 1 A.C. 212.

⁷⁰ See above n. 19.

⁷¹ *R. v. Kennedy* [2007] U.K.H.L. 38.

⁷² Law Reform Commission, *Report on Homicide: Murder and Involuntary Manslaughter* (2008, Dublin), paras 5.47-5.49. “The Commission still maintains that it is inappropriate to prosecute a person for manslaughter where they in some way facilitate another person to inject drugs and death is caused, because there is generally an absence of causation and more importantly, death results because of a free, deliberate and knowing act of the accused”: para. 5.51.

Definition of Serious Harm

The current definition of serious harm is “injury which creates a substantial risk of death or which causes serious disfigurement or substantial loss or impairment of the mobility of the body as a whole or of the function of any particular bodily member or organ”.⁷³ In our view it is difficult to know whether all instances where a miscarriage occurs could be classified as a “substantial loss or impairment of the function” of the womb, hence the requirement to insert this additional term.

Sentence

The offence of assault causing serious harm would attract a possible life sentence. The sentencing judge would retain discretion regarding the sentence to be imposed in individual cases.⁷⁴

Other Offences

In addition to assault causing serious harm, a number of other non-fatal offences against the person are relevant here:

- A person who supplies a pill to a pregnant woman who takes it voluntarily will not be liable for a poisoning offence under s. 12 NFOAPA 1997 because the voluntary decision to consume the pill is a defence.⁷⁵ A person who puts an abortifacient drug in a pregnant woman’s food or drink or who forces the woman to consume the drug would be liable for the offence of poisoning under s. 12 NFOAPA 1997 or for the offence of coercion under s. 9 of that Act, irrespective of whether it causes a miscarriage or not.
- A person who coerces a sex worker into obtaining an abortion would be liable under s. 9 of NFOAPA 1997 which criminalises coercion that seeks to force another to do an act. The abortion would be performed without valid consent and would constitute an assault causing serious harm under s. 4 NFOAPA 1997.

Key Questions for Further Research/Inquiry

In the course of preparing these proposals, we were struck by the paucity of research into the practice of abortion in Ireland, medical practitioners’ practical and ethical engagement with the prevailing law, and medical practitioners’ perspectives on abortion law reform. It is critically important that any future legislation is based on a critical and evidence-based evaluation of current medical practice as it relates to abortion care. We recommend that, as part of the process of developing abortion

⁷³ s. 1(1) Non-Fatal Offences Against the Person Act.

⁷⁴ On judicial discretion in sentencing see, for example, *D.P.P. v. Fitzgibbon* [2014] 2 I.L.R.M. 116. See also s. 4(2) Non-Fatal Offences against the Person Act 1997.

⁷⁵ s. 12(1) Non-Fatal Offences against the Person Act 1997: “A person shall be guilty of an offence if, knowing that the other does not consent to what is being done, he or she intentionally or recklessly administers to or causes to be taken by another a substance which he or she knows to be capable of interfering substantially with the other’s bodily function” (emphasis added).

legislation, the Labour Party should commission independent research into the following:

- How relevant medical practitioners envisage the tests in Heads 5-9 operating in practice, and the compatibility of those interpretations with the Guiding Principles in Head 3. Key issues include (i) the evaluation of risk in concrete circumstances, (ii) appropriate care pathways in the event that a woman's request for an abortion is refused,⁷⁶ (iii) the methods of abortion likely to become available in Ireland, and (iv) the accessibility of appropriate pre-natal testing.
- The likely interaction of abortion legislation and hospitals' ethos, particularly in the operation of hospitals' ethics committees.
- The capacity of prevailing disciplinary procedures for medical practitioners to ensure appropriate compliance with new abortion legislation, and to safeguard women's rights.

We recommend that in conducting such research or inquiries, consistent efforts would be made to critically compare prevailing Irish obstetric practice with international best practice, particularly in the areas of patient consent and patient participation in decision-making around medical treatment. In evaluating the data obtained through this process, we recommend that the Labour Party obtain feedback from expert medical practitioners based in other jurisdictions who have extensive experience of abortion care in a clinical setting.

We also encourage the Labour Party, as part of this process of law reform, and as a necessary precursor to the development of the Code of Practice in Head 16, to give due consideration to developing human rights compliant policy in the following areas:

- Mapping the anticipated public and private funding of abortion care services.
- Mapping the measures necessary to ensure that marginalised pregnant women have adequate access to abortion care, including developing care pathways (i) for minors, (ii) for women living in direct provision or in state care, (iii) for women whose capacity to make relevant medical decisions is in question, and (iv) for women whose first language is not English or Irish or who experience other language or literacy difficulties.
- Mapping the measures necessary to bring this Act into compliance with the Assisted Decision-making (Capacity) Bill 2013, once enacted, and with s. 57 of the Mental Health Act 2001. These will include the drafting of appropriate provisions to the Code of Conduct under Head 16. In particular, the Labour Party should consult on the appropriate interaction of this Act with the Capacity Bill's provisions on decision-making assistance agreements, co-

⁷⁶ On this point, it will be necessary, in due course, to take account of the outcomes of any reports or litigation arising from the 'Ms Y' case (i.e. the case of an asylum seeker, pregnant through rape, who sought (but was not granted) an abortion under the Protection of Life During Pregnancy Act 2013 on the basis that she was suicidal). For more on this case see, e.g., Máiréad Enright and Fiona de Londras, "'Empty Without and Empty Within': The Unworkability of the Eighth Amendment after Savita Hapappanavar and Miss Y" (2014) 20(2) *Medico-Legal Journal of Ireland* 85.

decision-making agreements, advance directives, decision-making representatives and the decision-making jurisdiction of the Circuit Court.

- Identifying the public and private groups and institutions most likely to provide abortion care services in Ireland in the event of new abortion legislation, and mapping their regulatory needs.
- Identifying steps to be taken to integrate abortion care into existing maternity and pre-natal care infrastructure.
- Identifying priorities for the expansion of crisis pregnancy services to ensure that pregnant women are fully informed of their new entitlements, and can access appropriate decision-making support. These priorities should be developed in the context of intensive consultation with existing pregnancy counselling services.
- Identifying the steps necessary to train Irish doctors and medical students to provide abortion care to a high standard, and to ensure subsequent quality assurance, monitoring and evaluation of care provision.
- Identifying the steps necessary to build institutional and professional confidence in interpreting the new abortion legislation in practice, so as to avoid the development of unnecessary ‘chilling effects’.

The process of policy development should invite extensive participation from a range of stakeholders in obstetric practice and abortion care, including relevant non-governmental organisations and human rights defenders. This process should also take account of women’s experience of crisis pregnancy and abortion care services where appropriate.